

A QUALITATIVE STUDY OF THE WOMEN AND CHILDREN'S RESIDENTIAL  
TREATMENT CENTER SUBSTANCE ABUSE TREATMENT PROGRAM

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A QUALITATIVE STUDY OF THE WOMEN AND CHILDREN'S RESIDENTIAL  
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THESIS

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## ABSTRACT

This thesis presents the results of a formative process evaluation of the Fairbanks Native Association Women and Children's Residential Treatment Center substance abuse program using interviews, participant observation, and grounded theory methods of qualitative research. Eight clients and eight staff were interviewed across the domains of culture, spirituality and family. A theory of program operation emanated from and was grounded in the data: program functioning was significantly affected by the relationship perceived by the clients to exist between themselves, (their needs, values, desires, goals and world view) and the program's goals and priorities.

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## I. Introduction

The purpose of this study is qualitative investigation of how the Fairbanks Native Association's (FNA) Women and Children's Residential Treatment Center Program (WCRP) addresses the needs of Native Alaskan women in substance abuse treatment. This study looks at ways in which cultural factors are integrated within the setting. Examples of such factors include; traditional and western worldview, effects of multi-generational grief, fetal alcohol syndrome, sexual abuse, domestic violence, parenting, and personal/community values specific to WCRP participants across program processes. In this study the term "program functioning" refers to ways in which the program actually functions to achieve its goals, the ways it actualizes them in its programs. Program functioning is primarily evaluated through the perceptions of clients and staff.

Program observations during this study occurred from November 1996 thorough October 1997. Subsequent to this time the program has undergone some fairly significant changes. The Program Director and Treatment Supervisor are no longer with the program, and the program name changed to Women and Children's Center for Inner Healing. Despite these changes the program still functions in the same setting and context and retains the same goals and objectives. Therefore, it is hoped that this study will be formatively relevant for programs attempting to implement a program of this model.

The significance of this study is reflected in the critical need for research addressing issues of Native Alaskan women participating in drug and alcohol treatment programs. Without an adequate base of qualitative information regarding patient perception of treatment features program implementation and continued development is impaired. Alcohol abuse is reported to be the most significant and urgent health problem facing Native Americans Moss, Edwards, Edwards, Janzen, & Howell's study (as cited in Naquin, 1995). The significance of the need for such research is further substantiated by Miller's (1986) report that elements typically included in alcoholism treatment programs in the United States are unsubstantiated by scientific evidence of effectiveness.

The need for research on treatment variables specific to Alaskan settings may be addressed by utilization of qualitative formative methodology. Patton (1987) points out that formative evaluations are particularly valuable in the early stages of a program implementation when there is likely to be a great deal of development and change, providing feedback about program processes and effects on program participants.

The design of this study is based on qualitative methods and grounded theory described by Strauss and Corbin (1990). Data were gathered via patient and staff interviews, follow-up focus groups and participant observation. Raw data were analyzed using the Non-numerical Unstructured Data Indexing Searching and Theorizing application, version 3.0 by Qualitative Solutions

Research (QSR). Investigation findings focus on development of grounded theory of program operation and development of process, formative findings, which may assist in program refinement.



## II. Literature Review

The phenomena of substance abuse and chemical dependency constitute a National problem of extreme magnitude. Gilliland and James (1993) characterize the problem as a National crisis, pointing out that complications involving chemical dependency are the most common problem presented for treatment and the underlying disease of addiction occurs more often than any other etiology. Gilliland and James describe the National substance abuse problem by the following:

- Alcohol is the number one substance abuse problem
- 85% of the drug addiction is to alcohol
- Between half to two-thirds of the US population use alcohol regularly
- One-third of the population drinks 95% of the alcohol
- There are 10-15 million alcoholics
- It is estimated that three million children and adolescents are addicted to alcohol

Roth (1991) identifies some dimensions of the problem as experienced by women:

- About six million women are alcoholics and alcohol abusers
- Over 70 percent of the women in treatment for alcohol and drug problems are survivors of incest or sexual abuse

- Alcohol and drug problems contribute to at least 50 percent of spouse abuse and sexual abuse
- Native American women have cirrhosis of the liver 36 times the rate of White women

Alcohol abuse in Alaska is of a substantially greater order of magnitude than that of the Nation. The Alaska Department of Health and Social Services Strategic Plan for the Division of Alcoholism and Drug Abuse (1994) points out that alcohol and other drug abuse is the single most pervasive and destructive health problem in Alaska. The Division's strategic assessment reports that Alaska exceeds the United States in at least three dimensions of alcohol abuse; (1) the percent of youth ages 12-17 using alcohol within the last month, (2) gallons of ethanol consumed per person age 14 or above, and (3) cirrhosis deaths per 100,000 persons. DHHS cites the disproportionate impact on the Alaska Native population pointing out that although Alaska Natives make up 15% of the Alaska population, Alaska Natives account for 46% of admissions to substance abuse treatment programs, 32% of inmates in Alaska prisons, and 35% of victims of child abuse.

The Alaska Federation of Natives (AFN) report, (1989) characterizes the crisis constituted by the problem of alcohol abuse as a "plague" and an "epidemic". The Alaska Natives Commission Report (1994b) reports that the alcohol mortality rate of Natives was nearly three and one-half times that of non-Natives (4.1/10,000 Natives, 1.2/10,000 non-Natives).

The Alaska Department of Health and Social Services estimates the yearly cost of providing all state government services attributable to substance abuse at nearly 300 million dollars (DHSS, 1994). Of the estimated 300 million dollars spent on government services attributable to substance abuse only ten percent is spent on prevention and treatment. On a broader scale, DHSS, (1994) indicates that less than one percent of all state government expenditures are allocated for substance abuse prevention and treatment. The extreme magnitude of the human, social and economic dimensions of the substance abuse problem provide a mandate for investigation of effective treatment strategies.

Notions regarding design of treatment strategy traditionally emanate from evaluation research. Two decades ago Patton (1978) addressed the lack of relationship between available research and program design decisions. More recently, the gap between available research and the design of effective treatment strategies was identified by (1986) where he pointed out that alcoholism treatment programs in the United States were primarily based on treatment strategies which lacked adequate scientific evidence of effectiveness.

Further, Miller asserts that it is not the case that research has not identified effective strategies but rather that such strategies are not being utilized in the design of treatment programming. Miller suggests that at least three broad-spectrum approaches have proven effective; social skills training, stress

management training and the community reinforcement approach. Miller additionally points out the need to match program features to individual patient need across variables such as alcoholism severity, family history, life problems, patient conceptual level and locus of control. A similar theme of findings is evident in the report by the Institute of Medicine (1990) in its national review of over 600 outcome studies. That report suggests that the following considerations may have direct bearing on effectiveness of treatment program design:

- 0. No single treatment approach is effective for everyone
- 1. Provision of specific modalities may enhance outcome
- 1. Treatment of other life problems may enhance outcome
- 1. Staff characteristics impact outcome
- 1) Patient characteristics are a determinant of outcome
- 0. Patient outcomes may take varying courses and
  - Patient outcomes may be a continuum of outcomes

The gap between available research and locally specific treatment strategy design is particularly evident in Alaska. A recent review by Naquin (1995) pertaining to Alaska cites only one statewide outcome study of treatment, the Kelso Study of 1984. Of particular importance is the need to address dimensions of treatment programming specific to the unique and diverse settings throughout Alaska. It is imperative that treatment design

considerations address local setting factors such as geography, culture, religion, world view, economics, and resource availability.

Of preeminent importance are unique factors of the setting integrally embedded within the matrix of experiential phenomena, which comprise the historical collective context of Alaskan Native people. Lowery (1994) points out that comprehension of the impact of colonialization on Native American lives is prerequisite to adequate understanding of the context in which the problem of alcoholism exists. There is not a robust body of empirical evidence that relates collective trauma and substance abuse within the Native American population. However, there is a growing body of literature that calls attention to the collective socio-cultural context experienced by Native Americans and portrays a thematic relationship between collective experience and individual health problems. It is not within the purview of this paper to argue that issue or attempt to substantiate a relationship between socio-cultural history and individual patterns of substance abuse. Given the WCRP program hypothesis that collective historical contextual factors such as world view, spirituality and intergenerational grief are underlying factors to consider in substance abuse treatment those factors are addressed in this investigation.

The necessity for consideration of multiple historical-contextual dimensions is pointed out by Napoleon (1991) in his conceptualization of substance abuse as being related to the destruction of the cultural underpinnings of Alaskan Natives. Napoleon links the epidemic rise in

alcoholism, homicide and suicide rates to devastation of traditional spiritual and family elements of culture in a spiraling sequence of events subsequent to the "Great Death" 1900 influenza epidemic. Similarly, the Alaska Natives Commission Final Report Volume II (1994) portrays substance abuse as both a symptom and a cause of problems which impact at a cultural, community and family level. The report points out that substance abuse is a symptom because it reflects a sense of powerlessness and frustration that result from loss of culture and traditional way of life. The report explicitly cites the need for development of residential substance abuse treatment programs which focus on traditional cultural values, spiritual and family healing.

Lowery (1994) addresses the importance of a historical-contextual perspective in understanding issues of Native American women and alcoholism pointing out that the impact of colonization is marked in Native American lives and is part of the context in which Indian Alcoholism exists. Duran and Duran (1995) similarly affirm use of a historical-contextual lens in conceptualizing issues salient to Native American survival stating that for five hundred years Europeans have attempted to subjugate, exterminate, assimilate, and oppress Native American people. Duran and Duran further point out that the effects of such subjugation and extermination have been devastating both physically and psychologically.

In a similar vein Segal (1997) identifies issues which may be problematic for Alaskan Native women. He proposes that for many Alaskan

Native women, behavioral and lifestyle problems arise from having to deal with the impacts of cultural change resulting from modernization of their traditional roles, which he sees contributing to a loss of personal, familial and cultural identity. A September 1997 WCRP report to the Advisory Board describes problems experienced by many program patients: 96 percent have experienced substance abuse in their family of origin; 69 percent have experienced physical abuse; 72 percent have experienced sexual abuse; 52 percent have attempted suicide; and 74 percent have experienced involvement with Alaska Child Protective Services. Consistent with Napoleon's (1991) and Duran and Duran's (1995) conceptualization of cultural devastation perpetuating a cycle of intergenerational trauma, violence, abuse and despair, Segal, Foote & Trojan (1997) identified "abuse reaction" to victimization as the single best predictor of treatment program non-completion. In an examination of factors related to relapse the study found the factors of "drinking and drinking effects" in combination with the "cultural identification, family relations and social support" factors as the best predictors of relapse. The study states: "It thus appears that events related to the extent of one's drinking problem and the extent to which women believe they have family support and a cultural identity, are important elements related to treatment success." Gutierrez et al. (as cited in Segal, Foote & Trojan, 1997) found a higher treatment completion rate for American Indian women who indicated they had practiced traditional activities while growing up and during the past year.

This study looks at how the WCRP program addresses elements of culture, spirituality, grief and family in meeting the needs of patients. The larger problem addressed by this study is the necessity for and urgency of expanding and enhancing the body of research pertaining to alcohol treatment programs in Alaska. The specific problem is the dearth of qualitative research at a community program level. Recognition of the magnitude of the problem of substance abuse and allocation of fiscal commitment proportionate to that need only constitute preliminary elements essential to implementation of appropriate solutions to the problem. At a more profound and elementary level are the questions of what to do and how to proceed. It would appear that the elements, issues and dynamics operative in substance abuse prevention and treatment are as diverse as are the people both individually and in groups who are the constituents of the substance abuse phenomenon.



### III. Program Description

The Women and Children's Residential Treatment Program (WCRP) is a program of Fairbanks Native Association, a private non-profit tribal organization in Fairbanks, Alaska. WCRP initiated services in July of 1994 under a grant from the Center for Substance Abuse Treatment with administration oversight by the Alaska Division of Alcoholism and Drug Abuse. The program provides for the geographical service area of Northern and Interior rural Alaska and the Fairbanks North Star Borough although women from all areas of the state are served. The target population is women age 18-45 and their children. Between July 1994 and January 1997 the program has served 91 patients with 86 percent being Alaskan Native Segal, Foote and Trojan (1997). The treatment milieu for the primary program is a single site, group residential setting. The transitional program is located in two apartment complexes within three blocks of the primary program center. Both are located among single family dwellings and apartment buildings in Fairbanks, Alaska. Patients are enrolled in the WCRP program primarily through referrals from the Alaska Department of Family and Youth Services, Alaska Department of Health and Social Services, the criminal justice system, other local agencies and self-referral.

WCRP's mission, as stated in "WCRP Policy and Procedures", is to "empower each woman to achieve continued sobriety, physical and emotional health for herself and her children; the skills for nurturing, effective parenting

and healthy family relationships, cultural and spiritual identity, education and employment and a sense of place in the community". The WCRP program is cited by Segal, Foote and Trojan, (1997) as the only Native Alaskan substance abuse treatment facility for women ages 18 and above in Alaska which allows children to participate in treatment with their mothers and attempts to reunite people with their culture.

The WCRP program consists of three principle components, (1) the primary treatment component, (2) the transitional component and, (3) the after care component. In addition to the three principle components of program organization, WCRP conceptualizes treatment into four phases. Phase one has a patient goal of stabilization with a theme of sharing your story. Phase two has a goal of recovery and main theme of creating your vision. Phase three is directed at the goal of resolving issues and has a theme of finding your voice. Phase four is referred to as "making connections". Phases one and two are integrated within the primary care component. Phase three is integrated in the transitional component. Phase four is the basis for planning of aftercare services. WCRP does not ascribe to a time delimited treatment regimen, as has historically been the case in substance abuse treatment programming. Individual patient passage through each of the phases is dependent on patient progress on the work comprising each phase.

The primary care component of WCRP is designed to serve up to 12 women and 30 children, age newborn through nine and addresses

assessment, pre-care services, and development of an individualized treatment plan. The assessment includes educational, psychosocial and biomedical conditions as well as chemical dependency. Pre-care services include a physical exam, TB tests, HIV risk assessment, pregnancy testing, and ATAP and general assistance services. The individualized treatment plan addresses the components of parenting, recovery and personal development and is explored further in this chapter. The parenting component addresses parenting skills, bonding, sibling issues, reunification, child development training and guided play. Both individual and group parenting sessions are provided. Services for children reunified with their mothers include prenatal care, birth, postpartum care, pediatric care, special needs assessment, provision of a state licensed childcare facility, developmental assessments and individualized service plans.

The primary care component facilitates treatment efforts through the provision of individual counseling and a variety of groups. Group work includes process group, 12 Step meetings, drug and alcohol education, issues group, Talking Circle, spirituality, grief group (although at the time of this study, patients reported that grief group was not occurring because of staff shortages), child development training and parenting classes, nutrition classes, patient presentations, family outings, crafts and guest lectures which cover such topics as domestic violence, Fetal Alcohol Syndrome and/or Effects etc., and cultural awareness activities.

The Education group addresses issues of basic substance abuse, life skills and wellness. Process group attempts to facilitate interpersonal dynamics including the ability of the patient to accept and give feedback and work through their defense mechanisms, particularly their extensive use of denial. The cultural awareness module focuses on story telling, arts and crafts, potlatches, dance and spirituality as a vehicle for transmission of cultural awareness, rediscovery and renewal of personal and collective cultural values. Personal development activities include behavioral contracts as may be needed, self-esteem building, educational development, career exploration and independent living skills.

The transitional component is designed to serve up to 8 women and their children without age restriction and is intended to provide a safe, alcohol and drug free, subsidized living environment with enough support to assist women to progress further in their recovery. Patient support within the transitional program is built up through patient linkages with community systems.

The after care after care is designed for women who graduate or leave either the primary or transitional program. The primary purpose is to provide temporary assistance to patients through an established, individualized referral network.

Phase one generally has a typical duration of approximately four weeks and is the stage during which the patient assessment is completed and the

treatment plan initially formulated. Five modules are primarily addressed including family assessment, individual counseling, initiation of the treatment plan, education, groups and cultural awareness. The family assessment module focuses on awareness of family member's function and roles. In this module patients develop genograms to facilitate discovery of their role and that of others in their extended family with regard to cultural history, and personal and cultural identity. The family assessment module also provides a springboard for investigation of familial relationships that contribute to substance use versus those which support sobriety.

Individual counseling during phase one is scheduled for three one-hour sessions per week. Counseling offered by WCRP is substance abuse counseling rather than individual psychotherapy. The major focus is primarily on implementation of the treatment plan, phase work and special issues that might arise during the course of the patient's residence in treatment

Phase two utilizes individual counseling and participation in all groups cited in Phase one. During phase two, patients integrate work on treatment objectives, recovery planning and implementation, and relapse prevention. Patients are supported in reconstructing their perceptions of self, family and community. Phase two, similar to phase one, also incorporates cultural awareness activities to foster continued development of personal cultural identity. Specific objectives to meet patient needs regarding sexual abuse issues, mental health considerations, domestic violence, anger management

and grief issues are primarily addressed through referral to community agencies.

The anticipated duration for completion of phase two is also projected to take approximately four weeks although both patients and staff report extended duration for completion of this phase. Individual counseling consists of one one-hour session per week.

Phase three provides guidelines for the transitional component. Modules included in phase three emphasize communication skills, aftercare protocols (including increased community involvement and the development of safety and discharge plans), individual counseling, life skills development, education and lectures related to literacy, family systems, decision making, employment assistance, and participation in groups focusing on self help programs, relationships, feelings and relapse prevention. Family recreation is also a module within phase three.

Individual counseling is available to transitional patients every two weeks for one hour as reported in WCRP literature. The anticipated duration of the phase three is 1 - 4 weeks although the transitional component is available to patients for up to one year.

Phase four is considered aftercare. Modules such as communication skills, aftercare planning and individual counseling are offered, similar to phase three. Employment and education are major focuses as well as attendance at self help and relapse prevention groups. Additional objectives

include family recreation, securing safe housing, joining an alumni group and accessing community programs.

The anticipated duration of phase four ranges from one month to 12 months. Individual counseling is available to the patient for one hour, once every two weeks.

The intake process of WCRP is substantially invested in development and compilation of a detailed, patient assessment profile regarding chemical dependency, providing for the assessment of chemical dependency, educational, psychosocial, and cultural factors. The cumulative result of this information produces a patient profile necessary to construct an individual treatment plan for chemical dependency. The treatment plan development process addresses patient problems, goals, objectives, time frame and staff assignment. Patient/counselor assignments are generally made on a random basis dependent on counselor caseload availability. WCRP's comprehensive treatment approach is similar to the broad-spectrum approach described by Miller (1986) in its view that drinking behavior is functionally related to other problems in the patient's life. Motivators, or environmental contingencies for change, however do not appear to be assessed to any significant degree. According to Meyers & Smith (1995), the motivators and/or events reinforcing a patient to not use are key factors that must be assessed with patients in treatment.

The intake assessment interview consists of nearly forty pages of questions and takes approximately two to three hours to complete in total. It is administered in sections by WCRP staff. A listing of intake interview modules and intake assessment instruments is found in Appendix C. The intake process utilizes an array of assessment data, the patient's DSM IV diagnosis, the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine (ASAM) Hoffman et al (1991) and the Michigan Alcohol Screening Tool to place patients in the WCRP program.

The treatment plan is developed in accordance with the six areas of the ASAM format addressed above. Although the ASAM model of treatment planning focuses primarily on substance usage and its effects, WCRP utilizes a more comprehensive conceptualization of treatment planning which is more in line with the broad spectrum approach characterized by Miller and Heather (1986). The premise of the broad spectrum approach is that substance abuse is functionally related to other problems in the patient's life and treatment planning which addresses this broader spectrum of problems is more effective than one which focus on substance abuse issues alone.

WCRP utilizes the ASAM Patient Placement Criteria as a focus in its treatment planning to formulate treatment problems, goals, and objectives. The ASAM criteria view treatment planning as an individualized process based on biopsychosocial assessment. The program utilizes assessment and patient



prioritization of problems to formulate the treatment plan, which specifies problems, goals, objectives, methods, and timetable for completion.

ASAM identifies six primary problem areas to be addressed in development of the treatment plan:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral conditions or complications
4. Treatment acceptance or resistance
5. Relapse potential
6. Recovery environment

The ASAM Patient Placement Criteria documentation states that the six primary problem areas encompass all pertinent biopsychosocial aspects of addiction.

Although the biopsychosocial basis of the ASAM model appears comprehensive, there is the possibility of misconstruction of treatment planning assumptions given that psychological issues are embedded within the context of the other six problem areas. A treatment paradigm which views psychological issues as separate and competitive with other addiction treatment issues may result in development of treatment plans which do not ascribe sufficient priority to mental health issues.

The ASAM Patient Placement Criteria is designed to optimize efficacy of care by establishing a system to match patient treatment needs with program resources available. Theoretically this approach serves to prevent placement of

patients with intensive mental health needs in a program which solely provides chemical dependency recovery. Practically, however, chemical dependency disorders frequently coexist with other mental health disorders. Evans and Sullivan (1990) indicate that individuals with a history of major depressive disorder or anxiety disorder have double the risk of the general population for substance abuse or dependence. The authors further indicate that coexistent chemical abuse rates for young chronically mentally ill patients exceeds 50%, among bipolar patients the rate is 20% and among persons with antisocial personality disorder the rate is 70%. Miller and Brown (1997) report that substance use disorders are the most frequently occurring comorbid disorders among patients with mental health problems and that the use of substances affects both the clinical course and prognosis for other mental health problems.

The frequency of co-existing mental health disorders and chemical dependency disorders presents two primary problems for a residential chemical dependency treatment program such as WCRP. First, the program must be able to effectively screen out potential patients not amenable to treatment, and second the program must be able to effectively provide resources and services to meet the coexisting mental health needs of residential patients.

Segal (1997) in his outcome research on the WCRP program indicates the critical importance of mental health factors as significant predictors of

treatment outcome. He points out that events related to patient drinking problems and the extent to which the women believe they have family support and a cultural identity are fundamentally related to treatment success. Segal specifically addresses issues of personal violence, sexual and physical abuse, patient support network and ethnic identity. The integral and pivotal impact of mental health issues is supported in Segal's assertion that many of the women entering treatment have experienced violence and victimization and that these issues are related to their substance abuse and to an attempt to harm themselves in some manner. Additionally, Spampneto & Wadsworth (1966) as cited by Segal note that sexual issues are important elements related to long-term recovery yet this aspect of treatment is frequently overlooked by substance abuse recovery programs.

It is important to recognize that a substance abuse recovery program designed to meet the needs of Alaskan Native women must address not only the chemical dependency dimension of the problem but more importantly the underlying coexistent mental health issues as well as other issues related to personal, family and community wellness, cultural identity and spiritual well being.

Another unique feature of the WCRP treatment planning process is the use of perceived choice as described by Miller and Hester (1986). The expectation is that use of perceived choice will produce greater motivation, involvement in treatment and more favorable outcomes. Perceived choice is

accomplished in WCRP treatment planning by means of involvement of the patient in the identification and prioritization of needs. From this prioritization and from information provided by the patient in the assessment, primary counselors then develop a treatment plan.

A primary feature of the WCRP program is the involvement of children in the recovery process. The holistic approach of the WCRP program places a primary emphasis on the patient and her children's relationship.

Children qualifying by age are enrolled in the WCRP after completion of the patient's two week black out period. Some exceptions are noted for children less than one year who may enter earlier, some at the same time as the patient's enrollment. Child development staff works closely with referring agencies such as Tribal Courts or DFYS in cases where those entities have legal and physical custody of children. In these cases, enrollment of the child may be delayed dependent on considerations outlined in case plans including, but not limited to, the number of patient relapses, the history of abuse and/or neglect, the length of time the child has been in foster care. Visitation schedules for these children are coordinated as applicable.

Intake paperwork is conducted by child development staff and the patient for all children enrolled in any of the three WCRP components. The child intake process takes approximately two hours to complete. Consents for releases of information between WCRP and service providers already working with the child are obtained at this time.

Initial and ongoing screenings and assessments are conducted on enrolled children. Some screenings and assessments are provided on site. Others, such as FAS/FAE and sexual abuse, are provided through referral to local or statewide agencies such as infant learning, children's mental health, and private physicians or clinicians. A complete list of screenings and assessments utilized at the WCRP program is included in Appendix C. Case management services are provided by child development staff who coordinate service provision both onsite and within the local community.

WCRP provides a state licensed child development facility in which the primary emphasis is on the social and emotional development of children with the primary focus on trust building. Language development, cognition and motor development are secondary focuses. Curriculum includes personal safety groups for children three years and older, violence prevention groups for children four years and older, and Children of Alcoholics/Addicts Group (COA) for children five years and older. Children also receive play therapy on site and individual counseling is available with the Child Development Specialist as may be needed.

Three classroom programs are available to WCRP enrolled children. These include an infant-toddler class, a preschool, and a school age program. Staffing is double the state required teacher/child ratios because of the special needs of enrolled children. These special needs include, but are not limited to, FAS/FAE, children who were prenatally exposed to or born testing positive for

cocaine, alcohol and/or marijuana or other drugs, and children with diagnosed mental health disorders such as Attention Deficit Hyperactive Disorder, Oppositional Defiant Disorder, Conduct Disorder, Generalized Anxiety Disorder, Major Depression, Post Traumatic Stress Disorder, and Adjustment Disorder of Childhood or Adolescence with Mixed Disturbance of Behavior and Conduct. Children who exceed the age limit for enrollment at WCRP are eligible to receive services such as limited case management, visitation, participation in children's groups and play therapy.

Individual service plans are developed for each child. Service plans address child history, referral and service providers working with the child, developmental objectives, and mental health or other special needs of the child. Parent participation in development of the child's service plan is required. Child development staff meet with parents to discuss children's progress and child staffings are held every two weeks.

The child development component is also responsible for coordination of some family services including parenting, child development training, and family activities. Parenting resources include the provision of individualized parenting counseling and group counseling utilizing the Parenting in Recovery program which specifically addresses addictive family relationship problems of trust building, limit setting, and anger management. Child development training is also provided and includes topics such as normal child development, children's play, and positive discipline. Family outings are scheduled weekly

and at the time of this study included family swim night, regularly scheduled Saturday outings to local community events and activities, and family participation in special cultural events.

At the time of this study, WCRP staff included a program coordinator, a treatment supervisor, a child development specialist, two primary counselors, two transitional advisors (one of whom was also assigned to provide after care services), eight child development staff, two family care staff, and five support staff including a registered nurse, a full time cook, an administrative assistant, and two van drivers/maintenance custodians.

#### IV. Method

##### Study Design

This study is a process, formative evaluation of how the WCRP program addresses the needs of Native Alaskan women in substance abuse treatment. Conceptualization of this study focused both on development of formative findings which may serve to improve program operation and on identification of ways in which the program meets the needs of participants that may be transportable to other substance abuse treatment programs providing services to Alaska Native women. This study methodology utilized qualitative techniques to develop grounded theory for a formative evaluation that will contribute to continue program improvement. Patton (1987) summarizes this process as:

"The evaluator's task is to generate program theory from holistic data gathered through naturalistic inquiry for the purpose of helping program staff and decision makers understand how the program functions, why it functions as it does, and the ways in which the impacts/consequences/outcomes of the program flow from program activities".

The patient population included ten women, of which 9 volunteered to participate in the study. One patient left the program against treatment advice, resulting in 8 patients in the study population. Patients ranged in age from 23 to 35 with a mean age of 31.1 years and median age of 32. The patient population is predominantly Alaskan Native including three Yup'ik, two Inupiat, and one



Aleut. Two of the eight patients are Afro-American. Patient treatment duration at the time of the study ranged from four months to 12 months. On average patients spend six months in the program. All of the patients had children in residence with them in the program. The number of children per patient ranged from one to three. The ages of children range from infant to 12 years old.

The staff interviewed included eight; the Program Director, Treatment Supervisor, Child Development Specialist, Program Evaluator, two Counselors, Shift Supervisor/Talking Circle Facilitator and Family Care Worker.

Participant observation data were recorded in a daily journal. Participant observation data were collected across all areas of program operation as detailed below under "Procedures".

### Procedures

Study data include interviews with clients and staff, participant observation data, and reviews of program documents and reports.

#### Interview data.

Interview data were gathered across classes of categories specified as domains. The interview guide is attached as Appendix A. The domains investigated include patient cultural background, patient perception of program response to cultural issues, patient perception of program response to grief, and spiritual and family issues.

An example of the coding process from open coding, to axial coding to selective coding is included in Appendix B. The process of open coding

involved querying the interview database using keywords associated with the domains of culture, spirituality and family. For example, words associated with the domain of culture were culture, tradition, potlatch drumming, dancing, hunting (cf. Appendix B). The process of axial coding examined client and staff perceptions of program operation. For example under the parts of the transcripts that included open-coding keywords associated with culture, I discovered more specific concepts that elaborated rigidity versus openness and open time versus structure (cf. Appendix B). The process of selective coding revealed an overall pattern of differences and similarities between staff and clients. For example, the concept of engagement versus client estrangement used between staff and clients here and throughout this study is intended to be similar to the idea of alienation. Axial coding indicated many clients were not engaged in cultural activities because they felt that they were not relevant, were unfamiliar, or didn't fit them. However, staff felt that they were the centerpiece of the program. Clearly, a pattern that emerged was a sense that clients felt alienated from this component of the program. For example Inupiat felt that "this does not apply to me". This sense of the clients is what is meant by estrangement.

One-hour interviews were conducted separately with each program participant and with program treatment staff. Findings derived from patient and staff interviews were further reviewed and clarified in a focus group conducted separately with staff and patients. Study data were organized utilizing the Non-

numerical Unstructured Data Indexing Searching and Theorizing application version 3.0 by QSR Ltd., Victoria, Australia.

#### Participant Observation Data.

Participant observation included client and staff program functions such as process group, individual counseling, education group, case staffing, staff meetings, spirituality group, potlatch, parenting group, nutrition group, food preparation, mealtime, child development activities and social functions. An example of participant observation in the child development component involved working as a teacher assistant in each of the four classrooms.

The degree of participant observation varied across client centered, staff centered or child centered activities. In client groups facilitated by treatment staff participation was limited primarily to observation. In client directed activities there was more direct participation solicited by clients. In staff meetings participant observation was limited primarily to observation. In child development activities direct participation was encouraged.

#### Review of Documents.

Document and report data reviewed included program grant, agency policies and procedures, program evaluation reports, agency treatment curricula, staff meeting minutes, case staffing reports, assessments, treatment plans, progress notes, and discharge summaries. Program documents were reviewed for patterns of program/client interactions that were revealed in axial coding such as openness versus rigidity.

### Analysis

This study utilizes the grounded theory method of qualitative analysis as described by Glasser and Strauss (1967) and Strauss and Corbin (1990).

Grounded theory is defined by Strauss and Corbin (1990) as:

"A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon." Lowery (1994) sees the development of grounded theory as transactional, contextual and processual whereby data are systematically analyzed through a process of coding, categorizing and dimensionalizing. Strauss and Corbin (1990) describe the elements of this process as breaking down data into concepts by open coding; developing, linking and recombining concepts through axial coding; and selection of the core category, relating it to other categories and development of the analytic story line through selective coding. All raw data was injected into the Non-numerical Unstructured Data Indexing Searching and Theorizing application version 3.0 by Qualitative Solutions Research (QSR) Pty. Ltd., Victoria, Australia, distributed by Sage Publications, Inc. The QSR system facilitated the development of ideas about the textual data and exploration of those ideas by means of a tree-structured index system comprised of hierarchical nodes. For example, a root-tree-branch relationship is developed from key-word searches across individual interview data. Macro concepts of the WCRP program such

as world view, spirituality and intergenerational grief are accessed across individual interview data by means of keyword searches such as family, victim, abuse, trauma and other similarly associated keywords. The QSR system uses keyword searches to structure parent-child hierarchical relationships between subsequent search files. The QSR system expedites database query, and theory construction by means of recombinant analysis and system closure that allows results of searches to be annotated and incorporated into the database providing a history of the analysis process and construction of new ideas from combinations of prior analyses. This data analysis system is very compatible with features of Strauss and Corbin's (1990) qualitative investigation model, referred to as "open coding" or breaking down the data into coherent categories, "axial coding" or relating categories along a common axis, and "selective coding" or the tying together of categories to form unifying theories about phenomena.

The grounded theory developed in this study derives from the conceptualization of the interview questions designed to investigate program implementation features and qualitative techniques of coding, refining, and discovering relationships between data made possible by the QSR data analysis program. These relationships were substantiated by triangulation or confirmation that similar patterns existed across data sets of staff and client interviews and other investigation sources. As client and staff interview data across the domains of culture, spirituality and family were investigated; taken

apart by open coding using key words, and put back together by axial coding of related categories and recombinant searches, a pattern of relationships in the data emerged, first as a triangulated story line and finally, as theory grounded in the data.

### V. Patient Profile

The names of participants have been changed to protect their confidentiality. All interviews were approximately one hour in length and conducted on site at the WCRP facility in private offices. The patient population included ten women, of which nine volunteered to participate in the study. One patient left the program against treatment advice, resulting in eight patients in the study population. Patients ranged in age from 23 to 35 with a mean age of 31.1 years and median age of 32. The patient population is predominantly Alaskan Native including three Yup'ik, two Inupiat, and one Aleut. Two of the eight patients are Afro-American.

The patient background includes a description across variables of age, ethnicity, education, substance use in family of origin, victimization/domestic violence history, marital status, number of children, DFYS status, abuse of children, criminal background, program diagnosis, age of substance first use and mental health history.

#### Patient One

Patient One is a single, 32 year old, African American, residing with family in an interior, urban setting prior to treatment entry. She was a self-referral whose drug of choice was crack cocaine. Patient One met the American Society of Addiction Medicine (ASAM) criteria for residential treatment and met the DSM IV criteria for Cocaine Dependence 304.20, Alcohol Dependence 305.20, and Cannabis Abuse 305.20 (sustained full remission), a MAST score of 25, and a current GAF of 40. She reported first using alcohol and marijuana at age 17 years and crack cocaine at age 23. The patient's daily alcohol use

was reported as a current pattern of 12 beers with the last reported date of use on September 1997. The last reported use of marijuana was in 1982, one joint per week. By the age of 27, the patient reported daily use of crack cocaine, the exact amount unknown although she mentioned having spent up to \$1000 per purchase for the drug. Her last reported use of crack was September 1997. It is unknown whether or not the patient's family of origin used alcohol or drugs. The patient did not report any prior treatment episodes.

Patient One did disclose that she had lost both an apartment and a home because of her substance abuse. Her educational level and work experience was not determined in the initial assessment. The patient did not disclose a childhood abuse history. She did, however, disclose that she had been convicted of and placed on probation for perpetrating domestic violence. Her most recent conviction for domestic violence occurred in 1995. The patient also disclosed five other alcohol-related arrests.

Christian beliefs were rated by the patient as being "very important" on a forced adjective scale. Traditional family values and practices were also rated as "very important" by the patient although she indicated limited participation in such events.

Biomedical complications included abnormal blood pressure, dental problems, blackouts and tolerance changes for both alcohol and cocaine.

Patient One was the mother of ten children. Her youngest child was adopted out to a sister. Only four of her children were in Fairbanks; the others



resided in California, some with their biological father and some in foster care. Three of the patient's children were enrolled with her at WCRP. Of these three children, the Division of Family and Youth Services had legal custody while the patient retained physical custody.

Patient One self-reported depression but was not on psychotropic medication nor did she receive mental health counseling. Suicide attempts were not reported. The patient was later involved in sexual abuse group at WCRP.

#### Patient Two

Patient Two was a single, 35 year old, Russian Orthodox, Yup'ik Eskimo woman from the western region of Alaska, where she resided prior to treatment entry. The patient met the ASAM criteria for residential treatment and the DSM-IV criteria for alcohol dependence 303.91. She reported an alcohol history initiating at the age of 11 with abuse starting at age 21 where she reported drinking approximately one gallon of alcohol once per week. Although the patient reported very sparing use of marijuana, the Clinical Director completing the assessment did not consider it an abuse/use problem. The patient reported a history of alcohol use by everyone in her family of origin. Four prior treatment episodes were reported in her initial assessment although two less were reported in her assessment at WCRP.

Patient Two was not homeless, had a high school diploma, and reported prior work experience as a postal worker. The patient did report that

she was physically abused by her mother from the age of seven to 16, that she was a victim of domestic violence perpetrated by a significant other, and that she was arrested six times for assault, MCA, and DWI was never incarcerated. Patient Two also self reported that she witnessed the murder of her boyfriend.

Patient Two rated both Christian and traditional Alaskan Native beliefs as “very important” but indicated only “some” involvement in special activities or traditions.

Biomedical complications included abnormal blood pressure, migraine headaches, asthma, and dental problems. The patient also reported having had two miscarriages and there was a report of an abortion in an earlier assessment, the result of a kick to the stomach.

Patient Two was the mother of three children, two of whom were enrolled with her at the treatment center. She disclosed physically abusing her children, all of whom were in legal custody of DFYS. Patient Two had physical custody of her younger two children while at WCRP. Her older son, who was not eligible to reside at the treatment center because of his age, was in local foster care and visited with his mother on a regular basis. While in treatment at WCRP, this patient’s middle son was diagnosed as having Fetal Alcohol Syndrome and her youngest child was diagnosed as having Fetal Alcohol Effects.

Patient Two did not self-report depression or other mental health needs but did receive extensive grief counseling through Hospice of Tanana Valley

and domestic violence counseling through the local women's shelter. One prior suicide attempt was reported.

### Patient Three

Patient Three was a single, 27 year old, Russian Orthodox, Aleut from south central Alaska, where she resided prior to treatment entry. The Division of Family and Youth Services referred this patient. The patient met the ASAM criteria for residential treatment and the DSM-IV criteria for Alcohol Dependence 303.91, Cocaine Dependence 304.21, and Cannabis Dependence 304.31. She scored a 31 on the MAST, presumptive of alcoholism. The patient reported an alcohol history initiating at the age of 14 years with her last drink, a 12 pack of beer, on September 1996. She first used cocaine at age 19 with her heaviest usage reported at 1 gram three times per month. The last reported usage was September 1996. Marijuana use was initiated at 18 years with the patient reporting that she smoked seven joints every day for about three months until it was no longer available. The last episode was on August 1996. The patient did report that both her mother and father used alcohol. She was involved in one other treatment episode.

Patient Three did not indicate that she was homeless and reported completing the 10<sup>th</sup> grade. Prior work experience in a cannery was indicated. The patient did report that she was physically abused by her father when he was drinking, that she was a victim of domestic violence perpetrated by a

significant other, and that she was arrested three times for assault and DWI but that she was not incarcerated.

Patient Three rated traditional Alaskan Native beliefs as “very important”, reporting that she was brought up in a family who practiced traditional holiday celebrations, discussed their heritage, and taught about Alaska Native ways. She reported attending church services about three to four times last year.

The patient other than her disclosure of having had many blackouts did not report Biomedical complications.

Patient Three had previously been married and was subsequently divorced. She was the mother of four children, three of who resided with their biological father and one who was enrolled with her at WCRP. DFYS retained legal custody of this child as the result of neglect and of his having been born cocaine effected.

Patient Three did not have a mental health diagnosis but did receive mental health counseling for anger management through Fairbanks Community Mental Health and counseling for domestic violence through the local women’s shelter. She did report one prior suicide attempt. She was also placed on psychotropic medication for anger management.

#### Patient Four

Patient Four was a single, 31 year old Inupiat woman from an urban, interior setting where she resided prior to treatment entry. The Division of Family and Youth Services also referred her. The patient met the ASAM criteria for

residential treatment and the DSM-IV criteria for Alcohol Dependence 303.91 and Cannabis Dependence 304.31, with Cocaine Dependency 304.23 considered in remission due to the fact that she had not used in the previous three years. She scored a 45 on the MAST, presumptive of alcoholism. The patient reported an alcohol history beginning at the age of 14 years with her last drink two weeks prior to entering WCRP. She reported drinking once or twice a day or all day, consuming 1/2 of a 5<sup>th</sup> of whiskey. Initial marijuana use occurred when she was 12 years old although it was experimental use at that time. At age 24, the patient reportedly smoked regularly for about three months and then quit. She began smoking again approximately four months prior to entering WCRP, with the last date of use on June 1996, the day she entered treatment. Cocaine use initiated when she was 18 years old and was last reported in 1993. Use was primarily on weekends, about one gram per time. This patient also reported binge uses of barbiturates a couple of times of month. First use was when she was 25 and the last reported use was in 1993. The patient reported the use of inhalants, three to four times, at the age of six. No other drug use was indicated. Patient Four indicated that both of her parents drank and that her brother had an alcohol problem. Extended family members were also reported as having problems with drinking. The occurrence of prior treatment episodes is unknown for this patient.

Patient Four reported that she was homeless upon entry to WCRP. She received a GED in 1981. Prior work experience included working as a waitress, a cashier and a laborer. She had not been employed for the past eight years.

Sexual abuse by two uncles was disclosed, occurring at ages seven and 11. This patient was also a victim of domestic violence perpetrated by a significant other. She reported five alcohol-related incidents with the legal system. She was never incarcerated.

The patient rated traditional Alaskan Native beliefs as “very important” and Christian beliefs as “somewhat important” although the importance to her of having traditional family values and practices was rated “somewhat important”. She stated that she experienced spiritual and cultural traditions while growing up; i.e. festivals, dancing and church but reported limited opportunities to participate as an adult.

Biomedical complications for Patient Four included physical cravings and many blackouts. The patient reported not having an OB/GYN exam in over three years. Physical complications included asthma, exacerbated by marijuana smoking and prior venereal disease.

Patient Four was previously married, having been separated for 12 years. She was pregnant seven times and has had two abortions. Two of her children have been adopted out. Her younger two children resided with her in treatment at WCRP and her older daughter was in foster care regularly visiting with her mother. DFYS retained legal custody of the three children who were removed because her youngest son was born testing positive for cocaine.

Patient Four did not receive mental health services but self reported past depression and the use of anti-depressants. No episodes allegedly occurred

after 1993. Three prior suicide attempts were disclosed with the first occurring at age 16 and the last 4 within the previous one to two years. The patient did receive group counseling for domestic violence issues through the local women's shelter.

#### Patient Five

Information for Patient Five was obtained from an Assessment Summary completed by a Correctional Center Inmate Substance Abuse Program June 1995 and from an Assessment Summary: Interview Supplemental conducted by WCRP in August 1996. Patient Five was a single, 25 year old, Yup'ik Eskimo who was initially admitted to WCRP because of her involvement with drug and alcohol related crimes and because of her involvement with DFYS. This patient resided in an urban, interior setting prior to her enrollment in the thirty-day program at the Regional Center for Alcohol and Other Addictions (RCAOA) which immediately preceded her initial entry into WCRP. This patient completed primary treatment at WCRP and was enrolled in the Transitional Program when she relapsed. She returned to RCAOA and completed the dual diagnosis program and then re-entered the transitional program where she was during the course of this study. The patient met the DSM-IV criteria for Cocaine Dependency 304.21 and Alcohol Dependency 303.91. The patient reported an alcohol history beginning at the age of 12, continuing through her initial incarceration. She reported weekend use of eight to 12 beers. Cocaine use began at age 19. The pattern of use was a couple of lines associated with

drinking. During the patient's relapse, immediately prior to her participation in RCAOA's dual diagnosis program, the patient reported using up to one gram of crack cocaine every other day for a three-week period. An individual, or possibly two, occurrence(s) of heroin use was also reported during this period. Alcohol use was reported in her family of origin. Information from WCRP staff indicated an incidence of cocaine use as well. The patient reported two prior treatment episodes.

Prior to treatment, the patient reported that she was homeless. She had never been employed and had not finished high school nor did she have a GED. There were no reported cases of physical or sexual abuse as a child nor was any involvement with domestic violence identified. There were two involvements with the criminal justice system, one for felony assault and another for probation violation. The patient was incarcerated and on probation.

The patient reported that she did not experience spiritual and/or cultural traditions while growing up.

Biomedical complications for Patient Five included thyroid disease and Hepatitis.

Patient Five was never married. She reported having had two abortions. The patient had three children and became pregnant during treatment. Three of her children resided with her in the transitional program. Her oldest daughter lived with her paternal grandparents. DFYS retained legal custody of the two middle children.



Patient Five disclosed that she was admitted to the psychiatric ward at Fairbanks Memorial Hospital due to seizures that she was having withdrawing from her alcohol and drug use. She indicated that she did not know why she was there but that she was asked questions about her suicidal thoughts. During treatment at RCAOA, a mental health assessment was completed by Fairbanks Community Mental Health and the patient was diagnosed with situational depression.

#### Patient Six

Patient Six was a single, 35 year old, Siberian Yup'ik Eskimo who was referred to WCRP by the Division of Family and Youth Services. This patient resided in an urban, south-central setting prior to enrollment at WCRP. The patient met the ASAM criteria for residential treatment and the DSM IV criteria for Polysubstance Dependence 304.81. She scored a 51 on the MAST, presumptive of alcoholism. The patient reported her initial alcohol use at age nine and her last use in November 1996. She reported current use of 1/5 of hard liquor three to four times per week. She first used crack cocaine at age 25. Her last use was reportedly in November 1996 at which time she smoked about three grams. Current usage was reported to be about four to five days per week, up to four grams per day. Marijuana use initiated at age 11 with the last reported use in November 1996 when she smoked 1/4 ounce. She reported current daily use, up to two grams per day. Amphetamines were used at age 26 with the patient reporting use a "few times" with about five pills each

time. Valium abuse was reported from age 16 to approximately age 33 – reporting her use as “once in awhile”. The patient also reported the use of inhalants with friends when she was 11 years old, about three times per week for a couple of months. The patient disclosed that her mother was a prescription drug abuser and that her father sometimes drank alcohol. The patient also reported that of her seven siblings, six have serious problems with alcohol. There were at least two prior treatment episodes.

Most recently, the patient resided in a south-central urban setting with an Inupiat man. Work history included employment with Learn Alaska, and the military. She had not worked in the twelve months prior to treatment entry. The last grade completed was 11<sup>th</sup>. The patient disclosed physical and emotional abuse by her father as a child and sexual abuse by a stepbrother and elders in her village as a child. There were reports of abuse and violence by her spouse and other domestic partners. Several incidents involving the legal system were disclosed beginning at age 17. Eight arrests had occurred with charges including, but not limited to shoplifting, criminal mischief, DWI, driving without a license and assault while intoxicated. There were periods of incarceration. She self-reported involvement in selling drugs and gang-like involvement including retaliation against others.

The patient identified that, as a child, she experienced spiritual and cultural traditions, attending church weekly and attending native potlatches, dancing and singing events. She does speak her culture’s language, took part

in traditional ceremonies, learned about Alaska Native ways and traditional values and beliefs from her grandparents and extended family. She rated Christian beliefs as “very important” and traditional Alaskan Native beliefs as “somewhat important” on the forced adjective scale administered during the assessment.

Biomedical complications for Patient Six included physical cravings, asthma, a heart murmur, knee problems and heartburn.

Patient Six was married and legally separated from her husband of ten years. Following her marriage, she had a common law marriage. Her most recent relationship has been short term (three months prior to treatment entry). The patient had six children and two miscarriages and did not have physical or legal custody of any of her children prior to admission to WCRP. Two of her children were born testing positive for marijuana at birth. Her children were removed from her custody by the Division of Family and Youth Services for neglect related to her drinking and drugging. Three of her children were enrolled with her at WCRP. During the treatment stay, one of her children was identified as having Attention Deficit Hyperactive Disorder.

The patient was treated for depression in May 1996 although she did not disclose the source of mental health services. Generational mental health issues were suspect. She reported suicidal tendencies and thinking in the past, one threat resulting in her hospitalization at Alaska Psychiatric Institute.

During this study, the patient did not receive mental health services through WCRP or through referral.

#### Patient Seven

Patient Seven was a single, 35 year old, African American, referred to WCRP by the Division of Family and Youth Services. This patient resided in an urban, south-central setting prior to enrollment at WCRP. The patient met the American Society of Addiction Medicine (ASAM) criteria for residential treatment and the DSM IV criteria for Cocaine Dependence 304.21 and Cannabis Abuse 305.23 – in full remission. She scored a 0 on the MAST, reporting that she never used alcohol. The patient reported initial use of crack cocaine when she was 17, 1/2 gram. The last date of use was reported as November 1996, at which time she smoked about 1.7 grams. Current usage was reported to be every day, all day, using all that she could get. The patient reported that she first used marijuana when she was 12, smoking every other day through 17 years of age. She reported that she had not smoked marijuana since 1993. The patient denied any use of alcohol or drugs by her biological mother who raised her. Her father who had moved out when she was a child was a heroin addict who died from an overdose. Her four siblings were reported as non-using. It is unknown from the Assessment Summary completed by WCRP staff whether or not this patient had any prior treatment episodes.

The patient was never married but was in an ongoing relationship with a man for over six years. They are not together at this time. Domestic violence

was reported in this relationship with the patient perpetrating such violence on one occasion. The patient disclosed that she was homeless for about two months over the year prior to treatment entry at WCRP. The patient completed high school and received her diploma. She subsequently attended cosmetology school but did not obtain a license. The patient did not report any work history.

The patient denied any physical or sexual abuse or neglect as a child. The patient indicated involvement with the legal system including three arrests, including one for writing bad checks and one for theft. No incarcerations were reported.

The patient identified that Christian beliefs were “very important” and rated the importance of having traditional family values and practices similarly although she reported only “some” involvement in traditional practices, values and beliefs.

Biomedical complications for Patient Seven included physical cravings and a broken leg.

Patient Seven had three children, all of whom were in the legal and physical custody of the Division of Family and Youth Services prior to her enrollment at WCRP. The patient was awarded physical custody of one child soon after her enrollment. This child was later diagnosed as having a disruptive behavior disorder.

The patient denied any treatment for mental health needs although she did report cocaine-induced paranoia. She also denied ever experiencing any thoughts of or attempts at suicide. This patient did not receive mental health services or domestic violence counseling during the period of this study.

#### Patient Eight

Patient Eight was a single, 31 year old, Inupiat woman, court ordered to treatment and referred to WCRP by adult probation. This patient resided in a northern rural community prior to enrollment at WCRP. The patient met the American Society of Addiction Medicine (ASAM) criteria for residential treatment and the DSM IV criteria for Alcohol Dependence 303.91, Cannabis Dependence 304.31 and Cocaine Dependence 304.21. She scored a 53 on the MAST, presumptive of alcoholism. The patient reported initial use of alcohol at ten years of age. The last reported drink was 1/2 bottle of hard liquor on January 1996. Current use was reported as every other day with consumption identified as up to a 5<sup>th</sup> of Rum. Initial cocaine use was established at age 18 with the last usage on January 1996. Current usage was reported as up to one gram once per week. Initial marijuana use was reported to occur at age 14. Last use was indicated as November 1995. Current usage was identified as 1/2 joint daily. The only other drug use reported by the patient was the use of a single hit of LSD at age 15. The patient indicated that both parents were alcoholic and reported that all of her siblings have had problems with drugs and/or alcohol. It is unknown from the Assessment Summary completed by WCRP staff whether

or not this patient had any prior treatment episodes but staff reported that there was at least one prior treatment episode in a rural community in the northern part of the state.

The patient was never married. Past significant relationships had been physically abusive. Patient Eight was not homeless. She attended school through the 11<sup>th</sup> grade and had worked as a bus driver since 1989, currently on leave from this position because of treatment.

The patient reported that she was a victim of physical abuse by both parents during her childhood. She was unsure as to whether or not she had been sexually abused because of blocked memories she experienced. This patient was heavily involved with the legal system, having been arrested approximately fifteen times for various offences including, but not limited to, assaults, DWI's, possession of cocaine, criminal mischief and minor consuming alcohol and prostitution. The most recent incarceration was served in 1994 with a court date in June 1996.

The patient reported that she was not raised in a traditional home and that traditional values were "not at all important" although she did speak her native language somewhat and did participate in some traditional practices such as feasts, healing ceremonies, etc.

Biomedical complications for Patient Eight included physical cravings, blackouts whenever she drank, Hepatitis and dental problems.

This patient was pregnant five times and had one miscarriage. Of her remaining four children, two were adopted out. Her youngest child was suspect for FAS/FAE but never diagnosed. The patient's two remaining children joined her at WCRP. While at WCRP, the patient's oldest son was diagnosed as having Childhood Depression by Fairbanks Community Mental Health. The Division of Family and Youth Services had been involved with the patient's children for about one year but the patient retained both legal and physical custody of her children. The patient admitted to physically abusing and neglecting her children.

This patient was diagnosed as having Post-Traumatic Stress Disorder. Past suicide attempts were reported at five times, the last in 1988 involving the use of alcohol. While in treatment at WCRP, the patient received extensive mental health counseling on site, was on psychotropic medication, participated in domestic violence group counseling at the local women's shelter, and participated in grief counseling through Hospice of Tanana Valley.



## VI. Client and Staff Perceptions of Program Implementation

The Women and Children's Residential Treatment Program is both visionary and unique in its multi-dimensional approach to the problem of substance abuse in Alaskan families. The integration of dimensions of culture, family and spirituality into a therapeutic family-based community offers a view toward the future and escape from past approaches to the problem of substance abuse. Seymour Sarason (1972) points out that the attractiveness of the future resides not only in the nature of its goals but in its presumed superiority to what existed in the past. The creation of a new setting involves implicit recognition of the failure or inadequacy on the part of existing settings. Sarason (1972) further points out that the creation of a new setting almost always involves conflict and controversy about how to handle new problems. Sarason (1972) describes the evolution of new settings:

Whereas at one time the future was seen as intimately related to, and an outgrowth of, a particular set of past conditions and experiences, this perceived and experienced relationship tends to fade out of the picture as the new setting is born or starts up, begins to organize itself, acquires material and human resources, encounters problems and pressures internal or external, and perceives that the accomplishment of future goals may be postponed or only partial.

One purpose of this investigation is the development of process evaluation useful as an external view in furthering the development and

refinement of dimensions of the organizational setting. One tool used here for the development of process evaluation is that of data triangulation as recommended by Denzin (1978) and Patton (1987). Data triangulation in this application utilizes data gathered from several sources addressing the same dimensions of program implementation. Implementation of program strategies across dimensions of culture, spirituality and family are triangulated by means of staff interviews, client interviews and participant observation.

### Client Perceptions of Program

#### Clients and culture.

Because the program was specifically designed to meet the needs of an Alaskan Native population, some modification was necessary to meet the needs of clients of other cultures. Both Afro-American clients indicated the perception that program expectations with regard to the dimensions of culture and spirituality were interpreted as Alaskan Native culture and spirituality. There was a point in time when racial tensions became apparent to staff and the focus on culture and spirituality was broadened to include Afro-American concerns such as the practice of Kwanza. In a similar vein, the balance of the client population was either Inupiat, Yup'ik or Aleut. None were Athabascan. However, because the program is located in interior Alaska, in proximity to Athabascan cultural resources, most program activities reflected that cultural heritage. Clients expressed concern that program activities such as potlatch,

dance, talking circle, food and local resource speakers were reflective of Native tradition other than their own.

One Afro-American client responded to the program focus on cultural renewal by taking the position:

I just really never ever bother with my culture. I know that I'm a minority and all that, but that's it. I never really wanted to search back, because that was hell enough back there how we were treated anyway, so I never wanted to go back that way...I like learning about this culture better. The Native culture here, the Eskimos, wherever they come from, the people here. I like learning about them more than myself.

Another Afro-American client addresses the experience of culture in the program:

I did a little bit of beadwork - I just dabbled and dabbed with it but I like those things. I don't care for their food, ya' know. That's my preference. They probably wouldn't care for my food either, ya' know. But that's okay, ya' know. But I learned, ya' know, I learned different things from them, ya' know. And I don't mind them learning different things from me.

This perception rather reflects the program's emphasis on the notion that content of an activity as culturally appropriate somehow makes that activity therapeutically significant. This fails to recognize that the value of an activity exists not in the content of the material, but rather in the quality of the experience, the experience of time, how that experience is shared in

relationship with others and what one chooses to do with that experience. Staff interview data corroborate client's complaints that activities designed to facilitate transmission of Alaskan Native culture were not reflective of those client's own culture, and were generally devoid of any experience relevant to Afro-American clients.

Considerable literature exists regarding differences between cultures regarding perception and use of time, in many contexts, including interpersonal, diurnal and seasonal variations. The use of time employed by the WCRP program was structured, rigid, punitive for noncompliance and the focus of many client's complaints. Client interviews indicate that the highly structured blocking of time and the rapid pace in center contrasted with the largely unstructured afternoons and evenings was frequently experienced as unfamiliar and stressful.

One client points out below, her perceptions of the program's structured use of time. This is in contrast to a large block of time in the evenings, which is unscheduled.

In the morning it's really busy, yeah, busy a lot. One class, next class, next class. You just got five minutes or ten minutes between classes to do what you gotta do to get ready for the next one... We have a lot of time in the evenings to relax and during the day, the afternoons when there's no classes. There's very few classes in the afternoon and that's good

because we all, that's our time to do our homework and get together and talk. Mostly in the evenings we get together and talk and have a little time. Several clients and staff alike indicate their need and desire for, program support for more open cultural, spiritual and social experiences as described below.

#### Clients and spirituality.

Client interviews indicate that the dimension of spirituality was imbedded in the program experience in three primary ways; church attendance, in-house spirituality group and events designed for transmission of cultural and spirituality experiences.

Although clients complained that the cultural resources used by the program were different from their own culture, these experiences frequently precipitated exploration into their own culture and spirituality. One client expressed her experience of culture and her newfound desire to seek out spirituality.

Living in Fairbanks is a lot different than living in Barrow.

Because in Barrow I haven't experienced that yet. I haven't been there to the Eskimo dances. Cause I know that they have spiritual experiences when they have the Eskimo dances, you could sense all that energy it's really strong. That will work for the clients. Once they get to learn about and understand where they're coming from, understand their culture and their history and their identity and their purpose they will want to get more

involved in their culture. That's what I'm doing right now. It's like since I learned all that I want to have more understanding. I want to go to Eskimo dances.

One Afro-American client describes her experience of spirituality as part of her culture. She also indicates that the program should focus more on her own personal context of culture and spirituality.

Well, I notice when in my culture, all I know is that I'm Black and I know I'm an Afro-American and I'm a Baptist. You know a lot of Black people are Baptists...I was raised in the church...My whole family, a host of cousins, we'd all be right in church every Sunday...Each weekend just be the whole family we'd all have a big dinner together. There was always togetherness...I remember that mostly in my background, in my culture when I was growing up it was church.

She goes on to express her desire for more religious practices in the program:

It's not enough. I have church in my room with my own self. I go into my room and read my Bible and pray and stuff. It seems like we should have a little bit more spirituality and reference to god.

Another client described how the program focused on culture and spirituality using local resources.

Last month in December what we had was a guest speaker and there were Elders from the community that would come and tell us about how they grew up. The ones I remember are how they grew up and what their

values were, what they did. They talked about Christmas time, what they did when they were growing up, how they hunted. What they were doing in December, January. The books we read were from Bethel area or Nome area. Not much from Barrow area, but I can relate to a lot of legends. They were told up there too, like changes, parts of it different. We talked about spirituality, art, culture.

Client experience of spirituality appears complicated, if not compromised by factors related to program Implementation. One such factor is the fact that client attendance at church is controlled by blackout restriction as a punishment. Additionally, client attendance at church is dependent upon client resources such as taxis or approved rides. Although there were spiritual and cultural program resources and activities available for Native-American clients there was a deficit of resources available for African-American clients. Staff and client interviews reveal the existence of racial tension and attributed this to the inequity in program resources and activities. Additionally, assignment of a young, inexperienced staff member as group facilitator may indicate a low priority of the program on spirituality group.

Despite program effects that detract from the experience of spirituality, many clients express a greater sense of spiritual and cultural groundedness and a desire to pursue those experiences and relationships. One client expressed her growing cultural and spiritual awareness as follows.

It was last week or a couple of weeks ago in spirituality I read out of a book and then I said a prayer before we started. That's my first time I ever did that. That was scary to do. And reading out from a book, to me reading in the Bible is one of my good spirituality experiences... And I learned a lot from that lady, she's really nice to have around and she talks about spirituality and our tradition... I wasn't very interested in it, until clear to the end that's where I got into it, I got interested in it. At first I didn't care, I didn't get too involved with that. But now I realize that there is something that I can learn about my culture. Because I didn't know anything about my culture when I came in here.

#### Clients and family.

The Program Director's description of clients experiencing family disconnectedness is an experience frequently reported by clients. One client's experience of family depicts how disconnected family has been for many clients:

My mother got pregnant with me when she was 15. My father passed, he OD'd on heroin. I felt nothing towards him because I didn't know him. He left my mom cause my mom got pregnant with me.

Another client reports the effects of substance abuse on her family:

Alcohol affected my family, all my family. All my family that died, even my dad, they died of alcohol, gosh... That's how my sister died, she was like only 19 years old when she died.



Family disconnectedness is also evidenced by the fact that only 5% of the children in the program were in the legal or physical custody of the mother, 60% of the children were in custody of the state or tribal council, and 90% of the clients reported physical or sexual abuse in their family.

Clients, staff and participant observation indicate that the family dimension of the program was primarily the responsibility of the Child Development component. Perceptions by clinical staff of the Child Development component as “babysitters” or daycare transmitted to clients. This served to block client perceptions of Child Development staff as professional partners in child and family growth and development. Gradually, as these perceptions changed, the Child Development component became recognized as the primary focus of program efforts within the dimension of family. Primary, family development efforts of the Child Development component included parenting skills training classes, and supervised involvement of parents in their child’s classroom and all aspects of their child’s growth and development. Additionally, the Child Development component functioned as a proactive family advocate in the process of mothers re-acquiring custody of their children. All clients specifically reported valuing the parenting experiences and child/family development activities of the Child Development Component. The following array of comments from seven clients reflects both on the need for child/family development programming and also

on the effects such programming has produced in reconnecting and refocusing families:

When I first got here, I must have been a mess, because I mean my thinking, my actions, everything, was twisted, real bad, because I was really loud with the kids and I got addressed for it. I would walk off and leave the kids and think that I could come back and it would be all right and I got addressed for that....They make sure you stay in tune with your children and even your outside support.

It was very hard to live here for that long, but now that I've got custody of my kids and we're non-using, and I'm trying to do things in my life, trying to better myself and my kids, trying to be a better parent. It's a lot better. It's a lot better today than it was six months ago when I was still pregnant. Now I have a direction where I'm going.

We talked about how it works when we were abusing and how it is now and how it could be if we want to change it. It's really good because I got a lot of those things I learned in parenting class and they really work, when to discipline and when not to and how to nurture our kids.

This is what's going on with me, I'm spending as much time as I can with my children. I never did that before.

I like the way this program is open for both mother and children because both the mother and child, you know, they get treated for such issues needed to be taken care of. Because the children need counseling for numerous things as emotional, physical, mental abuse and sexual abuse you know.

This program does just that, it puts the bonding back that the addiction has torn down between women and their children.

Anyway, I just have to be strong for me, my kids are going to be with me, you know, I that's real good for me. My son is getting big and we're going to have so much fun. There were so many times I wanted to just give up and leave and stuff, you know, and DFYS could take my kids, they could have them. All I was focusing on, I wanted to go out and get drunk, that weird thinking. And I don't have to think like that.

#### Staff Perceptions of Program

Staff perceptions of program implementation are based on interviews with eight staff including the; Program Director, Treatment Supervisor, Child Development Specialist, Program Evaluator, two Counselors, Shift Supervisor/Talking Circle Facilitator and Family Care Worker. All staff interviewed presented a consistent positive perception of program philosophy,

goals and objectives. All staff interviewed reported high regard for, and take considerable pride in, the conceptual construction of the program. The mission and strategy of program operation is collectively shared as a new, unique, pioneering and highly promising intervention by administrative and counseling staff. Historically there has been no adequate or satisfactory solution to the problems of family and community dysfunctionality stemming from substance abuse. The promise of a unique family-based residential intervention model, as conceived by the WCRP program, provides a mission for program personnel.

The WCRP Program Director indicates that the program model of family-based residential intervention is based on the idea that the woman is the historical bearer of the culture, that the mother is the person to go back to, in order to find out where the family and community roots are. The Program Director points out that the program has discovered that women in this context with substance abuse problems have largely become disconnected from family, culture and community and over time, the threads of family, culture and community become unraveled and lost to future generations. The WCRP program attempts to assist women and families in healing trauma, controlling chemical addiction, enhancing spirituality, and experience of community and family.

Interviews were conducted with the Program Director, Treatment Supervisor, three counselors, one monitor, the Children's Services Coordinator

and the Research Assistant. The interviews provided several different themes of staff perception regarding how the program was working, was intended to work, or presented problems for staff or clients.

The major themes of staff members emanating from the interview questions focused on how the program was functioning contrasted with perceptions of how it was intended to function. This relates in a broader sense to staff member's concerns with program components. The issues expressed concerned the definition of cultural orientation, therapeutic alliance between staff and clients, and staff differences about whether a psychological counseling model or substance abuse counseling model benefits clients.

Assessment of program implementation related to the dimensions of culture, spirituality, family and therapeutic alliance is essential to understanding program dynamics, given the program's theoretical underpinnings which focus on the rehabilitative potential of these variables. In a broader sense the efficacy of the therapeutic alliance is partly dependent upon client perception of congruence of their own views of culture, spirituality and family with those of the program. The variables of culture, spirituality and family appear to address dimensions directly related to varying degrees of individual client functionality and chemical dependency. Indeed, the program's assumption that an efficacious treatment of these dimensions may produce a therapeutic effect appears persuasive. However, staff and client interview data suggests, from several perspectives, that therapeutic movement is not being

optimized with regard to variables of culture, spirituality, family or therapeutic alliance. This appears to be related to the confrontational nature of the therapeutic relationship as practiced in the program. Yalom (1985) points out that the therapist posture toward a client should be one of concern, acceptance, genuineness and empathy. Rogers (1965) characterizes the therapeutic relationship as a freedom of choice and freedom from threat, one which moves toward openness and away from rigidity. Rogers further points out that not only are these features desirable in a client-therapist relationship but they are also important in a group or an organization.

The issue of confrontation is addressed by Miller and Heather (1986) who point out that although confrontation has long been viewed as a valuable if not essential element in counseling, a hostile-confrontational style is associated with more negative outcomes. Data gathered by participant observation, client and staff interviews, when triangulated, reflect WCRP's practice of more traditional substance abuse confrontational counseling techniques.

In one instance a staff member recommends the best strategy to negotiate with clients is to "look for the hammer" as a technique to insure compliance with program policy. Both staff and client interviews presented the common opinion that confrontational strategies used by staff created friction between both staff and clients and staff and staff. Some staff reported being so uncomfortable with the confrontational approach that they indicated a

preference for not working with staff that advocated and used confrontational techniques. The use of confrontation and an authoritarian approach is a strategy utilized by one key staff member. Staff members pressured to utilize an authoritarian stance report personally perceived and experienced stress from the conflict of their diminished empathy with clients as well as personal stress derived from supervisory pressure to be more authoritarian. One staff member stated:

Staff attitudes, staff ways of thinking, staff ways of doing things, and staff ways of treating these women, staff ways of listening, really listening to what they have to say, plays a big part in it and so I feel a lot of problems on the staff and counselors part is contributing to a lot of the problems here....Playing the women against each other, taking away a few basic rights, like no coffee, no candy and if they are caught with it they're on one week black out, no phone, no visitors, no activities, no TV or radio. They feel like they are in jail. They feel like their basic rights are being violated. It's pretty hard to learn to respect yourself when other people don't respect you. Punishment all the way, and it's just that, and some would say 'this is what I say, it goes, there is no discussing it, that is it'. But I have a different point of view, I give you one example to where I feel the girl's rights were really violated and it's just simple things. This one counselor went to this one girl's room, the counselor found a bottle of lemon juice, regular old lemon juice, and took the bottle, put it in the staff

conference room in the middle of the table and said, 'this is what I found in so and so's room. It is not allowed, because she had this in her room, she will go on one week black out. She cannot go on ladies night out. She cannot go to the Saturday outing and then she is on black out until next Tuesday or Wednesday.' I said, 'wait a minute, what's wrong with lemon juice?' And the counselor said, 'There is nothing wrong with lemon juice'. And I said, 'Okay, you agree with me, there is nothing wrong with lemon juice.' He said, 'my point is that she was not supposed to have it in her room'. I said, 'okay, can you negotiate some place else where she could keep it, maybe, and not be so hard with your consequences'. And the answer was, 'No, it's a problem. They got to learn. They cannot have this up in their rooms. If they do something wrong, they have to suffer the consequences'. Well, you see what I'm saying, the problems in this program, not only the ladies here have problems, problems come from staff too and a lot depends on how the staff interacts with the people and how they react with the girls here. That is going to make or break this program.

In this program the issues of authority, confrontation and punishment present a conflict between staff and between staff and clients. Interviews and observations strongly indicate that the program's use of a confrontational and punitive clinical approach impacts negatively on staff effectiveness. More importantly, the negative impact of this clinical approach on clients is widely



criticized. As noted above, Miller and Heather (1986) make the point that a hostile-confrontational style is associated with more negative outcomes. The American Psychological Association (2000), states: "The therapeutic bond formed between therapist and patient has been found to be a leading influence on a patient's recovery regardless of type of treatment used...". Yalom (1985), definitively points out: "The best research evidence available overwhelmingly supports the conclusion that successful therapy is mediated by a relationship between therapist and patient that is characterized by trust, warmth, empathic understanding, and acceptance". The impact of the confrontational and punitive clinical approach used by WCRP on both staff effectiveness and the staff-client therapeutic bond is an crucial issue, which demands further investigation.

#### Staff and culture.

Culture is a primary dimension of the WCRP program. The program Director pointed out: "we've discovered that these women have largely become so disconnected, not just in the culture, but from the family, that they're not the keepers of anything". WCRP strives to facilitate re-connectedness of cultural and family linkages through many program features. Staff report a variety of techniques such as: client assignments to research personal cultural and family history and tradition and present to the group; meetings with elders; talking circle; potlatches; traditional healing practices; sweat lodge, and other traditional and religious and spiritual practices. The Program Director indicated that development or renewal of such cultural and family linkages provide the

client: "...a connection, to usually a sober person, who knows the family and is dying to tell the story and then they have a real story about their family and they begin to build a connection there before they leave [WCRP]."

All program staff interviewed regarded the cultural dimension of the program to be a major component of the program. Staff reported that the program focus on the cultural dimension is an important factor in developing cultural and family linkages, connectedness and personal groundedness. The Children's Services Coordinator pointed out: "The program attempts to incorporate traditional culture for women through the provision of culturally relevant phase work and treatment plans, through spirituality group, through relevant workshops, through Talking Circle, and by having staff reflective of the cultural population of the women served". The Program Research Assistant, though involved primarily in data gathering rather than program implementation, sees the cultural dimension as being in the background, but spread across all program components while maintaining a focus specific to the culture of the clients.

One counselor indicated the role she feels culture plays in the program:

Yeah, I see there is a need for the community to come and work all together. Where I come from it is more 'us' than 'I', that thinking. And that is why I think there is a lot of need for that kind of community, and it is starting to happen. But it is like the clients we have, I think those that make it are those that have that community.

Another counselor views the cultural dimension of the program as a set of activities that are overlaid on the program:

Right, and so those things like we're promoting, this African dance workshop I think is nice. And having the Kwanza celebration, I think is a good message that we're wanting to accommodate everybody...I'm sure looking for specific activities that I can do in process group. I thought about it, but I don't have any, you know. I don't have a bag of tricks for that. I see it as a potential problem. I see it as something that is sort of a handicap to overcome. That is how I see it.

Another counselor indicated some conflict with how culturally specific activities were implemented:

When I first came into WCRP to do a talking circle, I don't know what I expected. I think I wasn't expecting the same kind of mood or atmosphere. I was totally shocked. They were not quite in a circle. They all talked at each other. The person holding the feather, the way I was taught, was the first person that needed to be speaking and everybody else listened. But no, they were, all the people that was there, were talking back. They were laughing. They were making jokes. They were coloring on paper. They were talking to each other. So, the talking circle at here at WCRP, I don't see as a talking circle. I see it as somewhat of a BS circle, because I didn't see anything come out of there that was from

the heart. And I didn't feel anything come out there from the heart and into healing and sharing and trusting circle, where you know it's not supposed to be brought out of that circle. I did not get that here in the WCRP talking circles. That's why I phased out of it. I did not want to do talking circles here, so I've been doing presentations.

The Treatment Supervisor indicated that the cultural dimension of the program is addressed in several ways:

We try to have a balanced staff that's one way, the other one is that we encourage different activities within their own culture. We provide opportunities for women to join in on things that have community, different Native healings, activities, spirituality kinds of things. We have had a traditional advisor in the past that would come in and teach beadings and sewing and talking stories, use the spirituality stuff to teach stories. We used to have an Elder that would read in the Athabaskan language, the Gwitchin language and she'd explain the story in English. That person is no longer with us. We have a lot of different books and music, children's books, those kinds of things certainly encourage culture.

She goes on to state:

I see a lot of reverse prejudice happening within their own people, and that is people who decide to be varying degrees of

assimilated, those people who are very pro-Native and I don't mean the people who are anti-Native are better. What I mean is, how do I put this, forcing people to go back to their old ways if they're going to be Native and I don't think that's right. That's just like forcing them to be something else.

Interviews and observations indicate considerable incongruence in the cultural dimension between the program's stated objectives and program implementation practices. Furthermore, progress toward cultural dimension objectives may be significantly impaired, given the Treatment Supervisor's reservations regarding transmission of traditional cultural values, as indicated above. This theme is further documented by another counselor who reflected on the importance of cultural experiences and the need for the program to provide such experiences:

I know that when I moved here from the village, the things that I needed that you don't see automatically is things like seeing and joining your friends and eating Native foods. And that is a big thing that is missed by a lot of people who move to town from the village. And one of the most important things to be able to do is to get or give Native food, share Native food. And that was something we started doing here. I, just myself, I like it a lot and so I'd bring, the first time I brought something it was salmon strips. And then I really realized how much it is missed by everyone else. And so like the next time I brought salmon strips and dry

meat and seal oil and muktuk and frozen whitefish. And we all sat down and we did this at least once a month for about four months. We'd all sit down and eat and it, man, it was great. That's something that's missed a lot. That's something you just automatically do in the villages and it is something that it just doesn't happen here. I remember I brought in four whitefish one time. There was eight of us and we sat down and we ate two. And then we thought, well, just let the other two thaw out enough for us to saw it up, and we ate the two frozen whitefish. And by the time we're done with that there was six of us left and we decided to saw up the other two frozen whitefish. And how I really knew I felt like I was really at home was, when we sawed up those two whitefish and one of them had eggs and nobody said anything. We didn't even have to say anything to each other. Where we saw it had eggs, we just all just automatically sat down. There was nothing left of that frozen fish by the time we left the kitchen. But that's something that it's a real need. And it's not, I don't know if it's something that you can say you miss it, but I don't know if it is a specific need that can be asked for and addressed and made available. Because I didn't see anybody else like going out of their way to make sure that it was given to them.

The program model, as presented, appears to constitute a unique and promising intervention. Staff and clients interviewed applaud the concepts of the program model, however in practice; staff and clients alike found many

problems with program implementation at the time this study was conducted. Evidence suggests that clinical leadership on crucial program issues such as therapeutic bond, confrontation, punishment, culture, and spirituality appears to contribute substantially to the pattern of problems identified by both staff and clients. It is interesting to note that the array of program problems identified by both staff and clients has in common the dimension of authoritarian style of program implementation. It is similarly interesting to note that the negative effects of the problems identified by staff and clients appear to impact most heavily the very principles, values, goals and objectives identified in the program model.

#### Staff and spirituality.

The program director indicated that features of the spirituality dimension were frequently also part of the experience of culture. Experiences like talking circle, presentations by elders, potlatches, and family grieving contain elements of both culture and spirituality. The Director stated that the program facilitates client spiritual experience through assigned readings, interviews, elder presentations, potlatches, spirituality group, and church attendance.

The program allows clients to attend the church of their choice within the community, unless they are being punished by restriction to the building. The program does not provide resources to facilitate church attendance, clients must obtain their own transportation.

Spirituality group, conducted on-site, was scheduled one hour per session, once a week. Attendance is mandatory at all group meetings in the program, under penalty of "black out", (client physical restriction to the program site without mail or telephone). At the time of this study there had been approximately an eight-week hiatus in spirituality group meetings due to staff turn-over. Following this, spirituality group was filled-in for a period of several weeks by two rotating counselors. Finally, a 19 year old night-monitor was permanently assigned as spirituality group facilitator.

Staff perspectives regarding the spirituality dimension of program implementation indicate a lack of an operational definition of spirituality, and absence of coherent articulation of program objectives in this area. The Treatment Coordinator summarized some of the problems experienced regarding spirituality:

And no one has clearly defined what people mean by spirituality. My definition of spirituality is very different than probably the majority of the people here....I think that is part of the problem, is that no one has come along and made a clear definition of what spirituality is, so that somebody has something to hold onto....However, what has happened is that people are forcing different kinds of spirituality on other people as being just spirituality but not knowing it's a religion....That's why spirituality needs to be clearly defined and I don't have a clear definition of it as far as, not in my own. What I'm kind of leaning toward is having



every Native group, every religion representative come through and share what they believe and why they believe what they believe.

Program efforts to achieve a wider exposure of clients to different religious beliefs appear to have resulted in some backlash and conflict between clients. Both counselors filling in for the spirituality group indicated adoption of a more subtle and ambiguous posture toward spirituality. One counselor stated that spirituality group should be left up to individual client personal experience. The other counselor indicated that he supported the Alcoholics Anonymous view of spirituality, as an individually and personally defined "higher power". Eventually, leadership of spirituality group was assigned to a 19 year-old Caucasian counselor-aide.

Participant observation as well as staff and client interviews indicate that elements of the spirituality dimension are interwoven with other dimensions in the program such as culture and community. Program counselors indicate their belief that participation and growth in culture, community and spirituality are essential to successful substance abuse treatment. They believe that these elements of the spirituality dimension have the potential to ground clients in culture, community and family as well as reinforce other aspects of program implementation.

The ambiguity and vagueness of the Treatment Supervisor's perception of both spirituality and culture in the program is reflective of how these

dimensions are dealt with in the program. The dimensions of culture and spirituality are areas of program implementation that deserve additional study.

Staff and family.

Similar to the dimensions of culture and spirituality, the dimension of family in the program is seen by program staff as a major program component. The Program Director sees disconnectedness from family as a major feature of the substance abuse pattern of program clients. In addition to the dimension of culture and spirituality, the program model is designed to specifically focus on the dimension of family. As with the dimensions of culture and spirituality; all staff interviewed spoke highly of the family component of the program model.

The Child Development Specialist interview describes above on pages 27-30, in detail, the activities within the child development component designed to address the needs of children and families. The child development component is largely responsible for most program activity within the dimension of family. Component activities focused on the areas of communication and problem solving skill development for children, parenting skills training and parent involvement in the classroom.

The counseling component utilizes two primary activities related to a sense of family; one, client contact of a distant family member to establish a sense of connectedness, and two, drawing of a "life chart" that diagrams the family tree in terms of substance abuse history. Actually, the counseling component of the program focused very little on strengthening families.

Spouse access to clients was highly restricted and spouse participation in the program was not supported. The counselors did not provide family counseling, instead they occasionally used referral to outside agencies such as Women in Crisis Counseling and Assistance and Fairbanks Counseling and Adoption. One of the two full-time counselors describes counselor participation in the family dimension of the program as limited to reinforcement of the parenting classes taught by the Child Development component.

I think most of the parenting work that we do is supervision of their interactions with their children. I think, you know, a lot of that's informal. The evening staff work with the clients to encourage them to try new parenting skills that they learn in their classes.

The Treatment Supervisor's observations regarding family needs of clients in the program is in contrast with what the program does regarding family needs.

Their family has basically disintegrated, not only their immediate family with their children and significant other or husband have no love for them, but also with cousins and brothers and sisters and mom and dad and grandma and grandpa, the relationship has been destroyed.

The reality is that program post-treatment clients nearly always re-enter a largely unchanged family or domestic environment.

It was the Program Director's perspective that the homework exercise of establishing contact with a distant relative was frequently the most significant feature of the program.

In their homework they have to go to a relative or a friend that knows this relative of that family and get a story. What it does is make them make a connection, to usually a sober person, who knows the family and is dying to tell the story. When they have a real story about their family they begin to build a connection there before they leave. Plus, it's one of those steps that they put off until the bitter end and they try everything to get out of it because they are terrified of talking to this person. We just say, 'well you know, you'll find it' and eventually they do and it's the greatest thing in their treatment practically.

The family dimension of program operation could benefit greatly from a reassessment of needs, re-design and re-tooling of program focus within the family domain. Instead of passively leaving the dimension of family to the night staff, or individual counseling incidents, the counseling component could proactively plan a network of positive and supportive intervention strategies. The child development component which has been largely responsible for most family dimension program activity should be involved in planning, designing and implementing this process. Client feedback and input into design and implementation on an ongoing basis is frequently a valuable resource and process.

One area of program operation in particular stands to benefit most greatly from client input into program functioning. That is the area of how clients experience time. The reactive, rigid, structured, scheduled context of a

treatment program environment is indeed in contrast with how time is experienced in the client's natural setting, be that village life or Alaskan city life. The unique elements of this program design such as culture, spirituality and family are subjective values acquired and reinforced by group experience and functioning. Such experiences and group functioning do not fit well in the context of the structured and scheduled treatment environment. One counselor made a similar observation:

Well, yeah. I think there's some irony here in the structure that we have, and the rigidity that we have in this program, paired off with the kind of people and the culture that we're dealing with. I really think that there's not enough time for informal, traditional learning.

A staff member, previously hired to do talking circle, also noted in her detailed example above regarding the whitefish group experience, that time is differentially modulated and experienced during acquisition and reinforcement of elements within the dimension of culture, spirituality and family:

And how I really knew I felt like I was really at home was, when we sawed up those two whitefish and one of them had eggs and nobody said anything. We didn't even have to say anything to each other. Where we saw it had eggs, we just all just automatically sat down. There was nothing left of that frozen fish by the time we left the kitchen. But that's something that it's a real need.

There is potential to improve program effectiveness in the dimensions of culture, spirituality and family by collaboration of counseling staff, child development staff and clients in the refocusing on program use of time and client participation in group experiences that reinforce traditional or at least familiar values.

## VII. Synthesis

The issues identified by clients and staff may be summarized into categories as seen in Table 1 below.

Table 1

Client and Staff Issues

Client Issues	Staff Issues
Cultural relevance, focus on traditional culture	Cultural relevance, focus on traditional culture
Structure of time	Structure of time
Disciplinary process, confrontation	Disciplinary process, confrontation
Therapeutic alliance	Therapeutic alliance
Support of spirituality	Support of spirituality
	Program/client collaboration

It is interesting to observe that the majority of problems or issues noted by the clients were similarly also noted by the staff. There is a high degree of agreement between clients and staff regarding areas of the program that could benefit from improvement. It is also particularly interesting to observe that the problem areas identified by both clients and staff are also areas of focus featured in the design of the program, i.e. culture and spirituality. Staff and clients identified those areas featured in the program design as the strengths of the program, yet those same dimensions were consistently identified as

problem areas by both clients and staff in their interviews. The fact that similar patterns of program issues appear across the domains of culture and spirituality for both staff and clients provides for some degree of triangulation as a check on the validity of the domains. From this theme or story line regarding program operation, one can propose how functioning of the program influences program effectiveness.

A theory how the program actualizes its goals and characteristically functions, emanates from and is grounded in the data: program functioning is significantly affected by the relationship perceived by the client to exist between themselves, (their needs, values, desires, goals and world view) and the program's goals and priorities. The term "program functioning" refers to program operation as described by client and staff interviews and participant observation. The common denominator among issues identified by both clients and staff was the clients' underlying perception of estrangement from the program with regard to a certain issue or issues. For example, where the issues focused on cultural relevance, clients expressed the perception that program features weren't congruent with their culture. Staff indicated that the program's difficulty in addressing the specific culture of each client stemmed from a lack of available resources. The phenomena of estrangement or alienation of clients from the program appears associated with the philosophy and practices of the Treatment Supervisor. Additionally, it appears that staff training and supervision provided by the Treatment



Supervisor served to replicate and perpetuate such treatment philosophy and practices.

Several clients expressed a sense of identity and pride in the program's focus on culture as a dimension of substance abuse treatment. However, they expressed a sense of disconnectedness because they felt the program was not relevant to their own culture. Clients and staff likewise reported a similar phenomenon with regard to the dimension of spirituality. Frequently, clients reported that program spirituality activities were unfamiliar to them. Additionally, the program's disciplinary practice of using denial of church attendance privileges or blackout further alienated clients from perceiving the program as fostering or supporting individual spirituality. The story line of client estrangement from the program appears to reflect the Treatment Supervisor's views and reservations regarding culture and spirituality as reported above on pages 68 and 72, respectively.

Another example of client estrangement from the program was in the area of programmatic structure of time. Clients and staff reported that the program's structure of time produced client tension and stress. Clients complained that the program schedule was overly rigid, structured and busy. Clients who were late or missed scheduled activities were punished with blackout. As discussed above on pages 70 and 77, two counseling staff observed the program as overly rigid and structured. Both staff recommended a

decrease in structure and increase in unstructured, informal time allowing more time for reflection and socialization.

Another area producing client/program estrangement, as identified by both clients and staff, was the area of confrontation, discipline, and therapeutic alliance. The story line reveals a pattern of client and staff differences regarding issues of confrontation, discipline, and therapeutic alliance. The Treatment Supervisor set the tone of the program and provided far-reaching direction across the dimension of client-program interaction. In this case the Treatment Supervisor's advocacy of a confrontational treatment style appeared associated with client estrangement from the program. Staff turnover was also related to issues of program treatment philosophy.

Although substance abuse programs have traditionally employed confrontation (Miller, 1977), not everyone subscribes to a confrontational treatment model. Miller (1977) disagrees with the conventional approach: "More aggressive confrontational tactics have a less than stellar record in alcohol treatment outcome research." He also notes, "Research points to the Rogerian quality of therapist empathy as a predictor of favorable outcomes." Client and staff interview data indicated a degree of client-program alienation associated with the program's confrontational treatment philosophy.

In striking contrast to the above, issues or problems regarding family/child development programming were not identified by clients. This absence of problems contrasts with the client-program estrangement reflected

in the domains of culture, spirituality, structure of time, and treatment philosophy. In fact, the family/child development component appears to be a very positive dimension of program operation. Staff of the family/child development component focused on the development of a positive therapeutic alliance with clients as contrasted with program treatment staff, and their efforts have apparently succeeded. It is an interesting irony that although clients and staff identified the cultural and spiritual features of program design as unique and promising positive dimensions of the program, in actuality, these areas appear to be associated with the greatest degree of client-program disconnectedness.

### Conclusion

This study did not investigate congruence in client-therapist relationships regarding personal characteristics, values or perspectives. Nor does this study attempt to investigate the strength or characteristics of the client-therapist relationship, although research regarding these dimensions may prove illuminating. This program is primarily a substance abuse treatment program that functions within and strives to be sensitive to the cultural and spiritual context of its clients. The recurrent story line that emerged from this study indicated that program functioning is significantly affected by the relationship perceived by the clients to exist between their needs, values, and culture and those of the program. Further study of the relationship between the program's use of confrontation and clients' perceived program-client

connectedness across the dimensions of spirituality, culture, and therapeutic relationship may prove useful.

### Recommendations

- The current study suggests that program use of confrontation, discipline, and punishment contravenes the therapeutic potential of cultural connectedness, family connectedness, spiritual connectedness and program connectedness. A major issue in psychotherapy efficacy research has been the salience of non-specific factors in therapy (e.g. warmth, empathy and therapeutic alliance) versus specific techniques. Yalom (1985) addresses the therapeutic relationship this way:

...*a sine qua non* in effective therapy outcome is a proper therapeutic relationship. The best research evidence available overwhelmingly supports the conclusion that successful therapy is mediated by a relationship between therapist and patient that is characterized by trust, warmth, empathic understanding, and acceptance.

Sullivan (1954) mapped the landscape of the client-therapist relationship with these seminal observations:

The chief handicap to communication is anxiety....As I use the term, anxiety is a sign that one's self-esteem, one's self-regard, is endangered....I would say that in general it has come to mean something that opposes what was presumed to be helpful. I have no great quarrel with the idea that anxiety may be regarded as 'resistance'".

One area for the program to consider is the quality of the therapeutic relationship as established in the program and how it affects the quality of therapy and healing accomplished by the program.

- The WCRP program has changed its name to Women and Children's Center for Inner Healing. It is of importance to the program to examine the program's culture, its values and world view, and how these affect the way it structures client-staff interactions at all levels and whether they are "healing".
- Many changes have taken place in the WCRP program subsequent to initiation of this study. For example, personnel filling key staff positions such as Program Director, Treatment Supervisor, Child Development Specialist, and all the counselors have moved on to other programs or job opportunities. The program could well examine its climate and the effects on staff and whether the issues identified in this study persist
- Although it is not unusual for programs of this nature to experience high relapse rates, six out of eight clients in the study have relapsed. It is important for the program to follow up those who relapse and if at all possible to determine the experience of the clients in the program and how it has effected their subsequent behavior.

A copy of this study will be transmitted to the current program director.

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## Appendix A

## Guide for Focus Group and Individual Interviews

Interview Type	Domain	Probe
Staff Individual interview	cultural background	Tell me about the cultural backgrounds and diversity of your patients
	cultural needs/issues	I'm interested in what you see as the cultural needs and issues of your patients
	culture and program	In what ways does WCRP address the cultural needs of participants
	grief, spirituality and program	How do you see WCRP addressing issues of grief and meeting the spirituality needs of patients
	family issues and program	The WCRP program speaks of dealing with domestic violence, abuse, FAS and parenting issues, in what ways does the program address these areas
Staff Focus group follow-up	cultural needs and issues	I would like to review and confirm the ways in which WCRP addresses cultural needs and issues

	grief, spirituality and program	You have indicated ways WCRP deals with grief and spirituality, can we explore further how this occurs
	family issues and program	Several ways in which WCRP addresses family needs have been noted, can we review what and how the program does in this area
Patient Individual interview	cultural background	Tell me about your cultural background, where are you from...
	culture and program	I'm interested to know how you see WCRP addressing cultural needs and issues
	grief, spirituality and program	Does WCRP deal with areas like grief or spirituality; if so in what ways
	family issues and program	What can you tell me about the ways WCRP addresses issues and needs of families
Patient Focus group follow-up	cultural needs/issues and program	I have heard ways in which WCRP addresses cultural needs and issues, I would like to explore and confirm ways in which this happens

	<p>grief, spirituality and program</p>	<p>I would like to review and follow-up on how you see WCRP helping to deal with grief and how the program affects spirituality</p>
	<p>family issues and program</p>	<p>Many have spoken about how WCRP has helped with issues and needs of families I would like to explore how this works</p>

## Appendix B

## Keyword Coding Example

Key words in open coding	Key words in axial coding	Concepts in selective coding
Culture, Tradition, Potlatch, Drumming, Dance, Hunting	Rigidity, Openness, Time, Structure	Client engagement versus client estrangement

Appendix C  
Intake Assessment Instruments

Intake Interview Modules

1. Referral information
2. Demographics
3. Personal history
4. Family history
5. Health and medical history
6. Legal status
7. Drinking and drug-taking behavior
8. Cultural issues and interests
9. Personal experiences (including history of abuse)
10. Domestic violence
11. Family functioning
12. Child assessment
13. Social Support

Additional baseline assessment data are gathered through administration of the Substance Abuse Subtle Screening Inventory, Index of Parental Attitudes, Generalized Contentment Scale, Index of Clinical Stress, Index of self-esteem and DSM IV diagnosis.